



[Billing Code: 6750-01S]

## FEDERAL TRADE COMMISSION

### Announcement of Public Workshop, “Examining Health Care Competition”

**AGENCY:** Federal Trade Commission.

**ACTION:** Notice of Public Workshop and Opportunity for Comment.

**SUMMARY:** The Federal Trade Commission (“FTC” or “Commission”) will hold a second public workshop on February 24-25, 2015, as part of the workshop series, “Examining Health Care Competition,”<sup>1</sup> to study recent developments related to health care provider organization and payment models that may affect competition and consumer protection in the provision of health care services. The workshop will be co-hosted by the Department of Justice, Antitrust Division (“DOJ”). Specific topics for discussion may include: early observations regarding accountable care organizations; alternatives to traditional fee-for-service payment models; trends in provider consolidation; trends in provider network and benefit design strategies, as well as contracting practices and regulatory activity that may enhance or undermine these strategies; and early observations regarding health insurance exchanges. This notice invites public comments on a series of topics. The FTC and DOJ (the “Agencies”) will consider these comments as they prepare for the workshop and may use them in subsequent reports or policy papers, if any. For additional information, visit the workshop website at <http://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition> or <http://www.justice.gov/atr/public/workshops/healthcare/2015/02/index.html>.

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<sup>1</sup> The first workshop in the *Examining Health Care Competition* series was held on March 20-21, 2014, and examined issues concerning occupational regulation, interstate licensure and telehealth, health information technology, and price and quality transparency. See <http://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition>.

**DATES:** The workshop will be held on February 24-25, 2015, in the Auditorium of the Constitution Center at 400 7th Street, SW, Washington, DC 20024. To be considered for the workshop, comments in response to this notice should be submitted by February 16, 2015. In addition, any interested person may submit written comments in response to this notice and workshop discussions until April 30, 2015. Prior to the workshop, the Agencies will publish an agenda and additional information on their websites.

**ADDRESSES:** Interested parties may file a comment for this workshop at <https://ftcpublic.commentworks.com/ftc/examhealthcareworkshop> online or on paper, by following the instructions in the Request for Comment part of the **SUPPLEMENTARY INFORMATION** section below. Write “Health Care Workshop, Project No. P131207,” on your comment, and file your comment online at <https://ftcpublic.commentworks.com/ftc/examhealthcareworkshop> by following the instructions on the web-based form. If you prefer to file your comment on paper, write “Health Care Workshop, Project No. P131207,” on your comment, and on the envelope, and mail your comment to the following address: Federal Trade Commission, Office of the Secretary, 600 Pennsylvania Avenue NW, Suite CC-5610 (Annex X), Washington, DC 20580, or deliver your comment to the following address: Federal Trade Commission, Office of the Secretary, Constitution Center, 400 7th Street, SW, 5th Floor, Suite 5610 (Annex X), Washington, DC 20024.

**FOR FURTHER INFORMATION CONTACT:** Stephanie Wilkinson, Attorney Advisor, Office of Policy Planning, Federal Trade Commission, 600 Pennsylvania Avenue, NW, Washington, DC 20580, 202-326-2084, [examininghealthcareworkshop@ftc.gov](mailto:examininghealthcareworkshop@ftc.gov). For more detailed information about the workshop, including an agenda, please visit the workshop

website: <http://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition> or <http://www.justice.gov/atr/public/workshops/healthcare/2015/02/index.html>.

**SUPPLEMENTARY INFORMATION:** The Federal Trade Commission and U.S. Department of Justice seek to better understand the competitive dynamics and effects of evolving health care provider and payment models. In recent years, changes in the way that health care services and products are delivered and reimbursed have been occurring in response to diverse market trends, including pressure to reduce costs and improve quality in the health care industry. The Patient Protection and Affordable Care Act (“ACA”) may have accelerated many of these changes. Providers are increasingly seeking ways to improve the coordination of health care services to patients. Meanwhile, payers are seeking ways to incentivize providers to practice more efficient, outcomes-based medicine and to avoid the overutilization of services and products. This workshop and comment process are expected to identify and examine strategies currently used by providers and payers seeking to reduce costs and improve quality, with a particular emphasis on the strategies’ potential implications for competition and consumer protection. Information obtained during this workshop and through comments will enrich the Agencies’ knowledge in this critical sector of the economy and thereby support their enforcement, advocacy, and consumer education efforts.

This Notice invites comments on a number of topics, including:

- The kinds of changes occurring with respect to health care provider organization and payment models;
- the economic, quality enhancing, technological, regulatory, and legislative factors that may be influencing such changes; and
- additional empirical research that would be helpful in evaluating these topics.

The Agencies are particularly interested in receiving comments on the specific topics discussed below, and this Notice includes questions as examples of the types of information that are likely to be helpful. Commenters should feel neither compelled to answer each question nor constrained by the questions listed.

*1. Early Observations of Accountable Care Organizations*

Accountable care organizations (“ACOs”) are networks formed by physicians, hospitals, and other health care providers to coordinate patient care. Although the term ACO is used to describe a wide range of provider collaboration, ACO members typically share clinical and financial responsibilities for designated patient populations, and are held accountable for the quality, appropriateness, and efficiency of the health care services they provide. ACOs can be structured to serve commercial patient populations, Medicare or Medicaid patient populations, or a combination of patient populations.

Some health policy experts and economists have raised concerns that ACOs might increase the ability of providers to obtain and exercise market power. For example, providers participating in ACOs may be able to exercise market power through collective negotiations with payers. Furthermore, in preparing to form ACOs, some providers argue that they need to consolidate through merger, claiming that increased scale and resources will better position them to achieve positive results as an ACO. However, this may lead to more concentrated provider markets.

In 2011, the FTC and DOJ issued a joint statement regarding the antitrust enforcement policy that would be applied to ACOs participating in the Medicare Shared Savings Program.<sup>2</sup>

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<sup>2</sup> See *FTC-DOJ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 60 Fed. Reg. 67,026 (Oct. 28, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf>.

Since that time, the Agencies have continued to monitor developments within the Medicare ACO programs, not only to enhance their understanding of these programs, but also to assess how they may impact the formation and operation of ACOs in commercial markets. For example, some health policy experts have observed that the Medicare ACO programs may encourage the development of ACOs that operate in commercial markets. Also, some have warned about the potential for cost-shifting from Medicare ACOs to commercial ACOs, which could result in higher prices for commercial patients.

Comments regarding early observations of ACOs might address the following types of questions:

- How are ACOs defined, and what are some of the challenges associated with clearly defining an ACO?
- How do ACOs operate? Are ACOs an effective mechanism for aligning the clinical and financial incentives of providers, payers, and patients?
- What strategies do ACOs use when trying to achieve the goals of reducing costs, improving quality, and increasing patient satisfaction?
- What are some similarities and differences between ACOs and patient-centered medical homes? Are there potential benefits to using these provider models in combination with each other?
- What preliminary observations can be made regarding the success or failure of ACOs that operate in Medicare, Medicaid, or commercial markets?
  - Is there any evidence of efficiencies, cost savings, or quality improvements?
- What preliminary observations can be made regarding the competitive impact of ACOs, particularly in commercial markets?

- Is there any evidence of cost reductions or quality improvements as a result of increased competition among providers participating in ACOs?
- What spill-over effects, if any, have been observed between Medicare and commercial ACOs, both positive and negative?
- Is there any evidence to suggest that ACO formation has been a mechanism for competing or non-competing providers to achieve and exercise market power?
- What impact, if any, has ACO formation had on patient referral patterns?
- Has the FTC-DOJ joint policy statement provided helpful guidance to market participants?

## 2. *Alternatives to Traditional Fee-for-Service Payment Models*

Traditional fee-for-service payment models reimburse health care providers for services rendered. Some have argued that traditional fee-for-service payment models have contributed to the high cost of health care in the United States because these models may create incentives to maximize the volume of health care services provided. In recent years, various health policy experts, providers, and payers have emphasized the importance of shifting away from traditional fee-for-service payment models toward alternative payment models that seek to use performance indicators and patient outcomes to reward higher quality and more efficient use of medical services.

Comments regarding alternatives to traditional fee-for-service payment models might address the following types of questions:

- What are the alternatives to traditional fee-for-service payment models, including either reforms to fee-for-service (e.g., maintaining a fee-for-service model and adding bonus incentives for achieving certain cost and/or quality benchmarks) or replacing fee-for-

service with some type of prospective payment approach (e.g., global payment, bundled payment, partial capitation)? How are these terms defined?

- Who bears the financial risk in each model?
  - How are prices established in each model? Is competition a significant factor in establishing prices for these models?
- How does the use of alternative payment models affect the incentives of payers, providers, and patients? How does this differ from the incentives created by traditional fee-for-service payment models?
- What are the challenges of transitioning from traditional fee-for-service to an alternative payment model?
- What are the economic, quality, legal, or regulatory factors influencing this shift away from traditional fee-for-service reimbursement?
- What impact, if any, do alternative reimbursement methods have on efficient forms of provider organization?
- Is there a relationship between the size and scale of a provider organization and its capacity to bear financial risk? What size and scale is sufficient for a provider organization to participate in existing or future risk-bearing programs?
- What are the competitive implications of this shift away from traditional fee-for-service reimbursement?
- Is there any evidence that alternative payment models increase competition among providers?
- Is there any evidence that alternative payment models improve coordination and quality of care or reduce costs?

- Is there any evidence of alternative payment models leading to restrictions on the availability of, or patient use of, essential health care services?

### 3. *Trends in Provider Consolidation*

Over the last two decades, there has been significant consolidation among health care providers, particularly among hospitals. Some economists and health policy experts point to this consolidation as a contributor to the rise in health care costs in the United States. The Agencies have a long history of analyzing this consolidation and bringing enforcement actions against specific mergers and acquisitions when they believe an antitrust violation has occurred. Since the passage of the ACA, some providers have argued that further consolidation is necessary to achieve quality improvements and cost reductions through more efficient health care delivery systems. The Agencies have long observed that in many cases providers may achieve these benefits through various forms of collaboration rather than consolidation.

Comments regarding trends in provider consolidation might address the following types of questions:

#### *a. Hospital-Physician Practice Consolidation*

- What economic, quality, legal, or regulatory factors may be influencing consolidation between hospitals and physician practices?
- What factors should be considered when analyzing the competitive effects of mergers of complementary service providers?
- What evidence exists regarding the competitive effects of these arrangements, both positive and negative?
- What does evidence show regarding physician service fees and facility charges following the acquisition of physician practices by hospitals?



- Is there any evidence that merged hospital systems and physician practices have more bargaining power than they would have independently, thereby allowing them to negotiate higher reimbursement rates or otherwise increase prices?
- What does evidence demonstrate about the quality of health care services following the acquisition of physician practices by hospitals?
- Is there any evidence demonstrating that common ownership (e.g., hospitals employing physicians or acquiring physician practices) produces better quality or cost outcomes than other forms of collaboration (e.g., physicians of different specialties forming organizations that are not owned by hospitals, or virtual networks of physicians)?

*b. “Cross-Market” Hospital Mergers*

- Is there theory or evidence that mergers between hospitals that operate in different geographic or service markets may increase the combined entity’s ability to negotiate higher reimbursement rates with health plans?
- If such mergers can lead to anticompetitive effects, what kinds of evidence and economic analysis would help to identify such effects?
- If traditional antitrust analysis of relevant product and geographic markets does not adequately identify anticompetitive harm in these situations, what other factors, if any, may help identify such harm?

*c. Provider-Payer Consolidation*

- What are the recent trends and some examples of providers and payers that have consolidated, or otherwise partnered, to offer integrated health care services and insurance plans to consumers?

- What are the competitive implications of such consolidation in both payer and provider markets?
  - Does this type of consolidation increase the incentives for exclusionary conduct or otherwise facilitate the exercise of market power? If so, under what circumstances?
  - Does this type of consolidation affect incentives to coordinate and improve the quality of health care, as well as reduce costs?
  - Does this type of consolidation increase competition in health insurance markets, by allowing providers to compete with payers?

#### 4. *Provider Network and Benefit Design*

There are many ways for health plans to design provider networks and benefits packages for consumers, which range from individuals purchasing health insurance to large national employers contracting for health insurance coverage for their employees. Recent developments include strategies that limit the number of providers in a network. Certain contracting practices or regulatory activity may potentially enhance or undermine the use of these strategies to spur competition among providers and reduce health care costs.

Comments regarding provider network and benefit design might address the following types of questions:

- What types of provider network and benefit design strategies have been implemented recently or are under consideration?
- What are the competitive effects of network design strategies that limit the number of providers in a network (e.g., narrow networks, tiered networks, reference pricing, etc.)?

- Can these strategies lead to cost reductions or improved coordination and quality of care?
- Are there circumstances under which they might create or facilitate the exercise of market power, or otherwise be anticompetitive?
- What is the relationship between market structure and network and benefit design?
  - Is robust provider competition a predicate for successful implementation of any of these designs?
  - Does concentration in health insurance markets impact provider network and benefit design strategies?
  - To what extent might some network and benefit designs enhance competition, even when provider or payer markets are highly concentrated?
- What types of provider-payer contracting practices may limit the implementation of these types of network design strategies (e.g., anti-tiering/anti-steering provisions, gag clauses, all-or-nothing contracting, and most-favored nation provisions)?
  - How prevalent are these contracting practices and which parties seek to include them?
  - What are the procompetitive rationales for adopting these provisions, and what are their potential anticompetitive effects?
  - To what extent might these practices affect incentives for innovation in health plan pricing models?
- What types of regulatory or legislative interventions may enhance or undermine innovative network and benefit design strategies (e.g., essential benefits and network adequacy requirements, any willing provider legislation, price transparency legislation, or prohibitions on certain provider-payer contracting practices)?

## 5. *Early Observations of Health Insurance Exchanges*

Most Americans receive health insurance through their employers. As a result of the ACA, individuals without employer-sponsored coverage can now purchase health insurance on public exchanges. Small group employers also can utilize public exchanges to make coverage available to their employees. In addition to public exchanges, private exchanges created by private sector companies, such as health insurance companies or consulting firms, also are emerging.

Comments regarding early observations of health insurance exchanges might address the following types of questions:

- How many and what types of plans are being offered on the exchanges?
- Who is buying on the exchanges and what types of plans are they choosing?
  - Have actuarial values and other information created greater transparency and helped consumers make meaningful decisions about the health plans that they purchase?
  - What does evidence demonstrate about the use of narrow provider networks in the exchange plan offerings?
- How do the state-based exchanges differ from the federally facilitated exchanges?
- How have the exchanges and related regulatory developments impacted competition in health insurance markets?
  - Have the exchanges had any impact on the pricing of health insurance plans?
  - Has there been entry or exit from the individual health insurance market as a result of the exchanges?
  - Have incumbent health insurers offered new types of products or lowered their prices in response to competition from the exchanges?

- What has been the competitive impact of the multistate plans and cooperatives?
- Have there been any discernible changes to concentration levels in health insurance markets since the exchanges were introduced?
- Have requirements like minimum benefits, medical loss ratios, and guaranteed issue affected competition among health insurers?
- How do the exchanges impact antitrust enforcement?
  - Is there potential for anticompetitive practices that may undermine competition on the exchanges?
- What are the recent trends in health insurance markets (e.g., increased use of private exchanges, increasing self-insurance by employers, employers migrating employees to public or private exchanges, increased small-employer coverage)?

You can file a comment online or on paper. To be considered for the workshop, comments in response to this notice should be submitted by February 16, 2015. In addition, any interested person may submit written comments in response to this notice and workshop discussions until April 30, 2015. Comments should refer to “Health Care Workshop, Project No. P131207.” Comments filed in electronic form should be submitted using the following web link: <https://ftcpublic.commentworks.com/ftc/examhealthcareworkshop> and by following the instructions on the web-based form. If this notice appears at <http://www.regulations.gov>, you may also file an electronic comment through that website. The Agencies will consider all comments that regulations.gov forwards to them.

A comment filed in paper form should include the “Health Care Workshop, Project No. P131207” reference both in the text and on the envelope, and should be mailed to the following address: Federal Trade Commission, Office of the Secretary, 600 Pennsylvania Avenue, NW,

Suite CC-5610 (Annex X), Washington, DC 20580, or delivered to the following address:  
Federal Trade Commission, Office of the Secretary, 400 7<sup>th</sup> Street SW, 5<sup>th</sup> Floor, Suite 5610  
(Annex X), Washington, DC 20024. If possible, submit your paper comment to the Commission  
by courier or overnight service.

Please note that your comment – including your name and state – will be placed on the  
public record of this proceeding, including on the publicly accessible FTC and DOJ websites, at  
<http://www.ftc.gov/os/publiccomments.shtm> and  
<http://www.justice.gov/atr/public/workshops/healthcare/2015/02/index.html>. As a matter of  
discretion, the Commission tries to remove individuals' home contact information from  
comments before placing them on the Commission's website.

Because comments will be made public, you are solely responsible for making sure that  
your comment does not include any sensitive personal information, such as an individual's  
Social Security Number; date of birth; driver's license number or other state identification  
number, or foreign country equivalent; passport number; financial account number; or credit or  
debit card number. You are also solely responsible for making sure that your comment does not  
include any sensitive health information, such as medical records or other individually  
identifiable health information. In addition, comments should not include "trade secret or any  
commercial or financial information which . . . is privileged or confidential," as discussed in  
Section 6(f) of the Federal Trade Commission Act ("FTC Act"), 15 U.S.C. 46(f), and FTC Rule  
4.10(a)(2), 16 C.F.R. 4.10(a)(2). In particular, do not include competitively sensitive  
information such as costs, sales statistics, inventories, formulas, patterns, devices, manufacturing  
processes, or customer names.

Comments containing material for which confidential treatment is requested must be filed in paper form, must be clearly labeled “Confidential,” and must comply with FTC Rule 4.9(c), 16 CFR 4.9(c). For any copyrighted material, please provide authorization (signed by the publisher or author if they retain the copyright) so that the material may be republished on the Agencies’ websites.

The FTC Act and other laws that the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. The Commission will consider all timely and responsive public comments that it receives, whether filed in paper or electronic form. More information, including routine uses permitted by the Privacy Act, may be found in the FTC’s privacy policy, available at <http://www.ftc.gov/ftc/privacy.htm>.

By direction of the Commission.

Donald S. Clark,  
Secretary.

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